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MANITOBA
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ASSOCIATION

Bulletin

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BOARD MEETING SYNOPSIS - OCTOBER 27, 2012

Task Force on Office Assessment: Dr. Robert Fraser presented to the MDA Board the proposed bylaw for office assessments. Some highlights include a committee structure with terms of reference, director of office assessment roles and responsibilities, six year cycle for office assessment, protocol for follow-up assessment or request for new assessment and relationship with other Provincial statutes, i.e.) workplace health and safety. MDA Board approved Bylaw 32-12 on Office Assessments

Continuing Competency: Dr. Nancy Auyeung provided the MDA Board with redrafted terms of reference for the Continuing Competency Committee. She indicated that there was a need to change the committee structure and mandate in order to meet the Regulated Health Profession Act. The MDA Board approved the Continuing Competency Committee terms of reference.

Communications Committee: Dr. Joel Antel provided the Board with an overview of the 2013 marketing and communication plan. Three goals of the program are: 1) positive positioning of dentistry in the public conscious; 2) increasing dental office busyness; and 3) reduce the number of communication Board complaints. Achievement of goals are attained by internal marketing, special events, and sponsorships. Integration of these approaches is the most effective tool in having a vibrant and effective marketing campaign. The MDA approved the 2013 Communication and Marketing Strategy.

All Dentist Musical: The MDA Board has asked that the proceeds of the Guys and Dolls musical be directed to CancerCare Manitoba – Head and Neck Division.

Trust and Value Working Group: Dr. Antel provided an overview of the communications programs across Canada. Presently all provinces are represented at the Trusted and Value Working Group. Main areas of focus are internal or in-office advertising on patient communications, national research on public opinion on dentistry, and sharing of information. Better decision making has resulted because

more practicing dentists encompassed the Trust and Value Working Group.

Budget: The following budgetary items were approved by the MDA Board – CDRAF assessment of \$21.45 per license dentist and \$3,150 MDA license fee.

MDA Staff Job Descriptions: Rafi Mohammed, MDA Executive Director, presented the new job titles and descriptions for MDA staff. He indicated that the new job descriptions and titles more closely reflect the reality of what each staff is doing. In summary the new job titles are: Director Public and Member Relations (formerly Membership Services Director); Administrative-Registration, Licensing and IT Services and Administrator; Peer Review and Licensing Support Services. Further, as per the 2013 approved budget a new Receptionist/Administrative Assistant will be hired.

Dentistry Canada Fund: The Dentistry Canada Fund will be closing down and must distribute the remaining funds to the CDA's 10 corporate members on a per capital basis. The MDA's share on a per capita basis is \$29,140. The MDA Board has directed these funds to Mount Carmel Dental Clinic to aid in the purchase of new dental equipment.

Dental Care for Residents of LTC Institutions: The MDA Board approved the terms of reference of the Dental Care for Residents of Long-Term Care Facilities Committee and appointed Dr. Margot Pilley as chair.

Foundations of General Practice Study Club: Dr. Joel Antel gave an overview to the Board about the concepts and rationale for the General Practice Study Club. One commonality for all new graduates is their experience as an associate in a dental practice, whether it was positive or negative and conversely, whether the practice owner saw it as a positive or negative experience. The purpose of study club is to provide a positive learning environment for new members of the dental profession. Two components: speaker series for new registrations of the MDA, and speaker

series for principal dentist bringing a new registrant to their practice. The MDA Board approved the terms of reference for the study club.

Economics Committee: Dr. White highlighted some of the key points from the 2012 Economic Survey: Patient attitudes and behaviors slowly changing to take more control on accepting dentist treatment recommendations; General Practice and Specialists are very satisfied with their professional careers; financial health and relationship with patients and fee alignment projects for specialist fees nearing completion. Dr. White also informed the Board that Mr. Michael Loyd will be stepping down as the MDA Economic Consultant in May 2013. Mr. Loyd has been the MDA Economic Consultant for 17 years. Furthermore, the MDA Board accepted as information the Economics Committee recommendations that includes the following: an overall increase in the MDA approved 2013 fee guides of 3.2%; an overall increase to the MDA approved Pediatric fee guide of 7.0% in 2013; an overall increase to the MDA approved Oral and Maxillofacial fee guide of 5.4% in 2013; and a 2013 budget request of \$150,000.

Dean's Update: Dr. Anthony Iacopino provided the MDA Board with an update of the Faculty of Dentistry activities for 2012. In his report he stated the following: Faculty is in a positive financial position and reinvesting fiscal resources to renovations; potential donation to the pediatric program to be announced in December 2012; Dean's Community Council still active and providing advice on clinical program; review of clinical fees charged to patients as patient pool keeps decreasing; and fulfilling part-time faculty staff needs.

CDA Report: Dr. Alexander Mutchmor provided an overview to the MDA Board on the following CDA activities and programs: National Dental Student Federation close to being formed; CDAnet Royalties payments distribution have been

Continued on page 5....



DR. AMARJIT RIHAL
PRESIDENT, MDA

President's Message...

As your newly appointed president I would like to take this opportunity to introduce myself to those of you that don't know me. I graduated from the Faculty of Dentistry at the University of Manitoba in 1995 and since graduation I have maintained a full time practice and am currently a partner in a large group practice. I have been fortunate in my dental career to have had opportunities in organized dentistry to represent Manitoba Dentists on a provincial and national level. The highlight for me was being installed as the President of the Manitoba Dental Association this past January. Currently, I am the Manitoba representative to the National Dental Examination Board (NDEB) and I will represent the NDEB on the Commission for Dental Accreditation of Canada (CDAC) starting in the fall of 2013. I also co-chair the MDA Mentorship Program with my classmate, Dr. Cory Sul, and I am a part time clinical instructor at the Faculty of Dentistry. Dentistry for me has evolved from a job or profession into a true passion. It is this passion that drives me to be involved in organized dentistry.

At this time I would like to welcome the new board members, Dr. Catherine Dale, Dr. Mike Cuthbert and Ms. Londa Theissen. I look forward to their input during our board meetings. I would also like to thank Dr. Andy Maxwell and Ms. Charlotte Athena Wilford as they leave the board for all their expertise and service over the years to the profession of dentistry in Manitoba.

In the Fall of 2012 the MDA proudly opened its doors to their new home at #202-1735 Corydon Ave. The Building Committee did a great job to ensure that the premises will serve the MDA, its members and the public for many years to come. If you have time, I encourage all members to visit the new office.

In what was the coldest weekend of the year, the MDA held a record breaking Annual General Meeting. With an attendance of over 2,300 participants, a great weekend was had by all. Attendees were impressed with the quality and diversity in the lecture content. I would like to say thank you to the Annual

Convention Committee, especially Dr. Carla Cohn and Dr. Tim Dumore, for all their hard work in what was a great convention.

In order to keep up with the growing technological demand, the MDA's current Content Data Management System (CDMS) is undergoing a major overhaul. We are currently in the testing phase of a new data management system. What this will mean to members is easier access to information and a more modern approach to account for continuing education hours. New technologies like CE swipe cards will be incorporated in the very near future for real time update of CE hours and you will see an option for the electronic delivery of member information, licensing renewals and bulletins if you so choose.

You will also notice a revamped Manitoba Dental Association website as well. For the hard working administrative staff at the MDA office this new CDMS will increase their ability to work more efficiently. There are also new security measures that will be added to protect the privacy of members' information.

There has never been a time in dentistry where things are changing at such a technologically rapid rate. The standard of the practice today is far different from that first summer of 1995 when I graduated. With the advent of digital technologies access to information is immediate, the complexities of treatments are increasing, and the breadth of materials and processes are expanding. Today's practitioners must educate themselves to keep on top of what is happening in order to provide the best possible care for our patients. The Office Assessment bylaw came into effect on December 14, 2012. To assist members in understanding the intent of this bylaw the MDA is currently working on providing online recourses for members. These online resources will help members with their office assessments. The feedback from current office assessments has been positive to date and will ensure that all practicing Manitoba Dentists will manage their offices in accordance with current baseline standards. The office assessment reviews aspects of dental practice

such as infection control protocols, privacy protection, office policies required under Manitoba statutes, office procedure manuals and much more. The assessment process will be a great value and education for office personnel and dentists alike. Each dental office is scheduled for an assessment every 6 years.

This year, under the leadership of our past president, Dr. Alan Cogan, the MDA Board participated in a Governance and Leadership workshop with Bud Crouch from the Canadian Society of Association Executives (CSAE). The purpose of the workshop was self-reflective and ensures that the MDA board is doing its due diligence on governing and managing dentistry in Manitoba. The workshop was extremely informative and the resulting changes will benefit MDA members and the general public.

One of the MDAs prime directives is to ensure that all members of the public have adequate and reasonable access to dental care. In October of 2012, the MDA hosted another Open Wide Clinic to provide a day of free dental care for those who cannot afford regular care.

With the help of the Manitoba Interfaith Immigration Council a need demographic was identified, landed immigrants and new refugees were treated. Over 250 immigrants/refugees individuals received dental treatment from volunteering dentists, dental hygienists and dental assistants. Some licensed dentists also volunteered their services in private practice to ensure all who come out on that day were provided with proper follow up care. This was a stop gap measure to help this demographic that is in desperate need of dental care. In order to ensure that this population has continual care the Manitoba Dental Executive expressed their support of provincially funded programs to new immigrants/refugees with provincial politicians.

Board Meeting Synopsis, continued from page 3...

resolved to ensure that the CDA maintain its non-profit status; Access to Care

Working Group Seniors and Children are recommending first visit to dentists by the age of one; iTrans is working on a referral project for the dentists of Canada; and Trust and Value Working Group continues to work on internal marketing campaign for dentists.

Annual Meeting 2013 Update: Dr. Carla Cohn reported on some of the

administrative changes to the Convention. Fees for Oral Health Members have increased to \$75.00/day and \$100.00/2 days; Presidents Dinner to \$125.00; online payment systems will be launched on November 1st and Exhibit fees have increased to \$1,150 in 2013 and \$1,500 for 2014. Social programs includes a performance by Harlequin for the Friday night social. Theme for 2013 is "A Walk Down Memory Lane."

Open Wide 2012: Ms. Linda Berg provided a summary to the Board on Open Wide 2012 held on October 20, 2012, at the Faculty of Dentistry. The

main focus of this year's event was the refugee population in Winnipeg as a result of the elimination of the dental benefits program for refugees by the Federal Government. 292 patients registered for Open Wide but only about 250 were seen. The remaining patients were seen at no charge by 4 members of the profession in their private practice.

With the disbanding of the Dentistry Canada Fund, the MDA received funds to distribute to a local charity of our choice. The MDA Board decided to directed these funds (\$29,000) to Mount Carmel Clinic for the purchase of capital equipment on behalf of all Manitoba members. Mount Carmel clinic provides dental services for approximately 3,000 people per year and were delighted to receive this much needed funding.

Siloam Mission, another community service agency, is always looking for volunteering dentists, dental hygienists, and dental assistants to help in any capacity. I personally have found my time at Siloam Mission extremely rewarding. If you have some time to volunteer please give Angelika Fletcher a call at (204) 956-4344 ext 327 or email at angelika.fletcher@siloam.ca.

There are more and more members in Manitoba that have been going on trips abroad to help the unfortunate. Whether it is to Kenya, Haiti, Vietnam, Peru or any other place in need, these acts of kindness reflect the spirit of professionalism and all members who reach out to help should be commended. In closing I would like to leave you with a quote that I found to be quite inspirational...

"Volunteerism is the voice of the people put into action. These actions shape and mold the present into a future which we can all be proud" - Helen Dyer

If there is anything that I can do for you feel free to contact me!

Best Regards,
Dr. Amarjit Rihal
President



DR. MARCEL VAN WOENSELE
REGISTRAR, MDA

Registrar's Column...

An area members regularly request information on continues to be records and their handling. This column is a reprint of information provided in an article I wrote in 2010 focusing on issues surrounding the storage and disposal of mainly physical records.

Please remember there are a variety of reasons for retaining records and every dentist must use their professional judgement based on underlying principles in their decision-making process.

Like collection, use and disclosure, storage and disposal are key aspects to managing a patient's dental records. There are three primary reasons for retaining records:

- Patient safety and clinical;
- Evidence in Disciplinary or Legal Procedures – there are legal obligations for disclosure to professional body or courts in a professional complaint proceeding or litigation (whether against the dentist or a third party - claim for injury in a car accident). Timelines are rarely defined;
- Audits - many government programmes require compliance with retrospective chart audits to confirm accuracy in billing.

Balancing the obligations to retain records is the expectation that personal information will be disposed of safely when the information is no longer needed for the purpose it was collected. You should not rely on a defined requirement for one purpose to determine the time period for record retention. The MDA does not have any specific bylaws or codified requirements for retention of records. The primary rationale the MDA does not specify a timeline is to avoid members inappropriately relying on it when there are other personal and professional purposes for keeping the records. There are many motives to retain patient records aside from regulatory reasons – patient care, government audits, evidence for litigation purposes, etc.

The legal recommendations on record retention vary greatly – from a specific number of years based on audit requirements to indefinitely. The risks and benefits should be assessed based on your particular practice circumstances. In almost every situation developing a written protocol for your office manual on storage and disposal of records would be beneficial. It ensures a consistent approach you and staff can rely on for decisions on record disposal.

An appropriate protocol should include:

- methods for informing patients and staff of protocol;
- notification, - if any - to patients at the time of disposal;
- details about the notification process;
- if relevant, record specific timelines (i.e. study models vs. x-rays vs. daily treatment records);
- storage and disposal of electronic records;
- how requests for transfer of original documents will be managed;
- methods to ensure secure storage and disposal of patient health information
- office staff responsible for implementation; and
- any specific circumstances or conditions that would preclude disposal under the protocols.

Continued on page 9...



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JOIN THE TOOTH FAIRY FOR A FUN- FILLED DAY AND VOLUNTEER IN YOUR COMMUNITY

The Manitoba Dental Association is once again a proud sponsor of the Winnipeg International Children's Festival. "Tooth Fairy Saturday" takes place on Saturday, June 8, 2013 from 10:00 a.m. to 4:00 p.m. and we need your help!

Volunteers Required:

6-8 Dentists (GP or Specialist)
2 Orthodontists
8 Dental Assistants or Hygienists

The volunteer shifts are:

Set-up - 9:00 a.m. – 10:00 a.m.
Morning - 10:00 a.m. – 1:00 p.m.
Afternoon - 1:00 p.m. – 4:00 p.m.

It's a fun day where the volunteer dentists perform a dental screening on children aged 6 months to 12 years, with orthodontists on hand to offer a quick consult if needed. Every child receives a "goody" bag containing a toothbrush, floss & paste and a prize.

If you are interested in volunteering please contact: Linda Berg, Director Of Public & Member Relations at (204) 988-5300 ext 3 or lberg@ManitobaDentist.ca before May 17, 2013.

Join the Tooth Fairy and educate kids about the importance of oral health!

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Registrar's Column - Continued from page 6...

Specific legal advice may be helpful in developing in-office protocols for storage and disposal of the records.

Members are expected to be reasonable and responsible in the collection, use, storage and disposal of patient information. Long term relationships or complex treatment situations may require longer retention periods than individuals presenting on a one time basis.

In regards to storing and securing patient health records, I have spoken with representatives from the Provincial Ombudsman's Office and Manitoba Health. They both indicated there is some flexibility in the discretion provided to trustees of personal health information but if a complaint is initiated, the investigation would look to the reasonability of measures used to securely store the records.

No system can be completely secure but in order to demonstrate reasonability there are some simple steps you may perform.

- develop a clear written protocol for the collection, use and storage of personal health documents including:
 - a. who is authorized to access the documents;
 - b. protocols during office hours to prevent unauthorized access by members of the public;
 - i. location and visibility of computer monitors;
 - ii. requiring supervision of the reception area at all times if this is area separating waiting room from chart area;
- if cleaning personnel are not authorized to access personal health information, proof of bonding available in your written protocols may address potential concerns;
- ensure all staff members are informed and comply with the written requirements.

Developing the written protocol is an important protection for trustees of health records to address concerns about storage protocols. It would be expected in any future renovation of the office a closed system for securing patient records would be included. Please provide a copy of your written protocol when completed.

Yours sincerely,

Marcel Van Woensel
Registrar, Manitoba Dental Association

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DR. ALEXANDER MUTCHMOR
BOARD OF DIRECTORS, CDA



CANADIAN DENTAL ASSOCIATION

Hello again! After devoting my last article to the JCDA Oasis project, I thought that I would like to take this time to talk about a couple of the CDA's recent activities that are related more to our advocacy role.

I'll start with the Minamata Convention. In January, in Geneva, the United Nations Environmental Programme (UNEP) International Negotiating Committee (INC) completed negotiations on the establishment of an international treaty on mercury. This treaty is designed to reduce the release of mercury into the environment when used by people across the globe. Initially, it was looking like there was the potential for a complete ban of all uses of mercury worldwide.

After four years of negotiation, the CDA, in conjunction with the FDI World Dental Federation, the WHO Oral Health Programme and the International Association for Dental Research (IADR), were able to advocate successfully for a reduction in the use of dental amalgam (versus a ban) through increased attention to dental prevention and health promotion, increased research and development of alternatives, and best management techniques for amalgam waste. As a result, it is expected that the impact of the Minamata Convention on Canadian dentistry will be minimal. The use of dental amalgam in Canada is declining and best management practices are already in place in almost all dental practices. In the medium to long term, the phase down provides an impetus for the development of better restorative materials and for stepped up prevention efforts that will be positive for the oral health of Canadians.

On another front, in June 2011, the Canadian Forces (CF) engaged in a new mission in Afghanistan: Operation ATTENTION, Canada's contribution to the NATO Training Mission in Afghanistan. Its mission is to support the Government of

Afghanistan as it generates and sustains the Afghan national security forces, develops leaders, and establishes enduring capacity in order to enable accountable, Afghan-led security. The Canadian Forces Health Services, including the CF Dental Corps, have been engaged in this mission from its inception. Our teams in Afghanistan began by focusing on building the Afghan National Army (ANA) "Dental Corps" from tactical to strategic levels. They soon came to recognize that the issues facing the country's military dentistry capability could not be solved by simply focusing on the ANA. It became evident that the educational, civilian and military sectors must grow and succeed together for any of them to succeed. Therefore, the CDA is collaborating with the Canadian Military Dental Corps in developing and providing an integrated mentoring program for Afghan dentists, both civilian and military. CDA's participation will consist of providing advice to Afghan dentists in the establishment of a National Afghan Dental Association; giving access to some of CDA's knowledge instruments, such as the JCDA; and sponsoring the Afghan National Dental Association into the FDI World Dental Federation as a member and providing support and advice for their participation in FDI over the next two years.

I'd also like to mention CDA's advocacy of the first visit to the dentist by age one. As evidenced by numbers of children treated in hospitals for severe caries, early childhood caries remains a significant problem with the potential to adversely affect the general health of the child. The dentist, through a comprehensive review of an infant's medical history, oral evaluation, and environmental context, can identify patients at special risk for compromised oral health. If a child is seen within six months of the eruption of the first tooth or by one year of age, risk factors such as medical and social history, feeding patterns, presence of enamel anomalies, oral hygiene practice

and fluoride availability can be identified, allowing the dentist, to determine special risk, appropriate interventions and/or periodicity of future dental assessments.

Therefore, as part of its plans to fight early childhood caries, the CDA is conducting a special initiative to promote a 'First Visit to Dentist by Age One'. This is a project emanating from the current CDA position statements and the work of the CDA National Coordinating Working Group on Access to Care, which is initially focussing its activities on children and seniors.

In the first phase of this project, the firm Navigator has been approaching Canadian dentists to complete a robust, scientifically sound survey of their views and standard practices with respect to seeing children in their practices. Next, a complete and thorough analysis of

the data obtained from the survey of Canadian dentists will be undertaken to determine the requirements for an internal communication initiative aimed at dentists on the benefits of a first visit by age one. This will be followed by a promotion/education initiative aimed at other health professionals to ensure that all Canadian health professionals are supporting CDA's position.

These are just a few examples of the very important, but perhaps not overly visible, in which your CDA is playing a very active role.

I'll be back with more, in the next Bulletin.

Dr. A. Mutchmor, DMD
CDA Board Representative

JACK STOCKTON, DMD, CFP, MBA , FICD

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THE DENTAL SPECIALIST

"The Dental Specialist" is written by Manitoba Dentl Specialists. Each issue features one of the dental speciality groups (on a rotational basis). In this quarterly's issue, the article is submitted on behalf of the Prosthodontists.

Occlusion; The Achilles Heel of Dental Implants

One of the most challenging aspects of prosthodontic and restorative dental treatments is dealing with the occlusion. Providing a stable, balanced, biologically acceptable occlusal scheme is crucial to the long term survival of prosthodontic dental treatments, and most certainly dental implant treatments. Suffice it to say, that decisions about how to treat the occlusion; how to establish a proper occlusal scheme and how to provide and maintain a stable, balanced biologically acceptable occlusion for a patient begins long before the implant is placed. The decision-making starts at the first clinical examination of the patient. Diagnostic casts, mounted preferably on a semi-adjustable articulator are invaluable and in fact any prosthodontic treatment cannot be diagnosed or treatment planned properly until such casts are obtained. There is no substitute for this. Furthermore, when a patient is missing a tooth or many teeth, and has arrived at the dental office for a consultation; then it is paramount that, not only should diagnostic impressions be made, and the resulting dental casts mounted, but a diagnostic wax-up should be done. This wax-up, which can be done quite easily by a dental technician, gives an incredible amount of information to the dentist. Tooth size, shape, aesthetic concerns, edentulous space parameters, osseous support for the proposed implant relative to the required exit angle of the implant, current occlusal scheme and the required occlusal scheme are just some of the important factors that are gleaned from a diagnostic wax-up.

When natural teeth are going to co-exist in the same arch and/or opposing arch as the dental implants, then a thorough and complete examination of all teeth is required. A complete periodontal exam including probing, mobility, mucogingival attachment, furcation involvement, is required. Have the teeth adjacent to the implant site been treated with endodontic therapy? Are the teeth adjacent to the implant site or opposing it, in need of endodontic treatment or re-treatment? If re-treatment is required, what is the expected prognosis?

An example is in order: A 45 year old male patient arrives for an implant consult for tooth #11. It was knocked out in a hockey accident 20 years prior. He is missing a number of posterior teeth on each side. The remaining posterior teeth have shifted, due to tooth loss, resulting in the patient only having one opposing pair of teeth in light occlusal contact on each of the right and left posterior quadrants. All remaining teeth are periodontally healthy. The anterior teeth are bearing a significant portion of the occlusal load such that they are in mild fremitus. Teeth numbers, 12, 21 and 22 are retroclined, have existing root canals, prefabricated

posts and crowns. The anterior teeth display 4.5 mm of overbite and 0 mm of overjet. A high smile line, thin biotype and enough osseous support to place an implant without the need for grafting, completes the picture. Clearly, this is not a case of simply placing the implant into an edentulous space that has excellent bone; many other factors must be considered.

How the occlusion should be designed and managed is a decision that must take place in the diagnostic phase. Other questions that may be asked, are: what are the consequences of mismanaging the occlusion? Is occlusal parafunction a contraindication? Does a history of periodontitis require alternate approaches?

It is important to understand that there have been no "gold standard" scientific studies that directly compare one occlusal scheme, versus another in human subjects. We will look at some of the science that has been done and extrapolate from there, developing a risk factor analysis that will allow us to analyze which issues involving implant occlusion are important.

The classic monkey study was done by Isidor (C.D.I.R.: 1996; 7: 143-152) who placed 10 implants at the crest of bone and created ligature induced plaque retention with resulting pocket formation, loss of attachment and loss of marginal bone; mean bone loss was up to 2.0 mm with no implants becoming mobile. No implants were lost. Eight other implants were placed and were overloaded occlusally. There was mobility but no pocket formation and no inflammatory infiltrate. Bone loss was up to 5.0 mm and 5 implants were lost.

Miyata (I.J.O.M.I.; 2000; 15; 425-431) did a controlled occlusal overload study on 4 monkeys. Two implants per monkey were placed with 4 weeks of occlusal load of 0/100/180/250 microns. The 180 micron "high" load showed 50% bone loss. The 250 micron "high" load showed bone loss to the apex.

Esposito, (J. Oral Science 1998, 106; 527-551) did a met analysis of 73 articles where 3013 implants were placed and looked at over 5 years. There were 259 failures. Occlusal overload was the causative factor in 90% of the cases.

Richter (Premature contact on teeth; JOMI; 1995; 10: 99-108) studied premature contacts on teeth and implants. As you increased the prematurity on teeth, the load stayed the same (PDL feedback mechanism). As you increased the prematurity on an implant, the load increases as well (no PDL).

Jacobs and Van Steenberghe (Clin. I. Res, 1991. 2: 75-80) studied



the oral tactile function with teeth and implants. They studied the patient's ability to perceive thickness between: tooth to tooth; tooth to implant; implant to implant. A "high" contact is less perceived between an implant and a tooth and between an implant and an implant. Teeth intrude more than implants under axial load. A greater height of occlusal contact (i.e. a larger occlusal prematurity) on an implant is "needed" before it will be perceived as being "high" in occlusion.

Jacobs and Van Steenberghe (I.J.O.M.I. 1993; 8: 549-554) studied the passive threshold level of implant supported prosthesis and teeth; forces were gradually increased on teeth and implants and it was found that implants needed 50 times the force before the load was perceived.

Randow and Glantz (Acta. Odont. Scand. 1986; 44: 271-277) showed that a greater load may be applied to non-vital teeth.

Omar and Wise (J. Oral Rehab 1981; 8: 209-221) showed that mandibular flexure can be an issue. When the mandible opened, the teeth "moved" lingually about 200 microns, when the mandible closed with a "squeeze" the teeth "moved" buccally about 150 microns.

Misch (Misch; C. Dental Implant Prosthesis page 479) showed that under a 3-5 lb load, teeth exhibit a sudden initial movement that ranges from 8 microns to 28 microns in a vertical direction. This initial movement is PDL physiology. As the force intensity on the tooth is increased gradually, the tooth movement continues but this movement is a gradual rise. This secondary tooth movement is a tooth-bone movement. The movement on an implant is similar to the secondary tooth-bone movement.

Sekine (Tissue Integration: Excerpta Medica 1986) discussed that a healthy implant moves less than 73 microns and the human eye cannot detect mobility in the 50 to 100 micron range.

Rudd, O'Leary and Stumpf (Periodontics, 2: 65-68 March 1964) described horizontal tooth mobility in carefully screened subjects. Shillingburg, Hobo, Whitsett displayed this in diagram form in their text Fundamentals of Fixed Prosthodontics, 2nd Edition 1981, page 27. Maxillary anterior teeth have a natural horizontal movement of 56 to 108 microns.

Anterior implants will not move immediately but under heavy load, may move from 10-50 microns. When 2 implants oppose each other, the combined movement may be zero microns. The opposing implants may only move under heavy load while two teeth that oppose each other will move quickly under light load and potentially as much as 112 microns.

It becomes obvious that the biomechanical mismatch between two implants that are in function, versus two teeth that are in

function, can be enormous and ultimately, deleterious to the implants.

In summary; the quantity and quality of occlusal stops, tooth mobility, and restorative status of the teeth, immediately adjacent to any proposed implant sites, are of extreme importance. As well, the presence of a stable, functioning anterior guidance is crucial when placing any posterior implant.

Implants are not teeth, and a whole new set of guidelines must be developed in order for our implant treatments to stand the test of time.

The direction of occlusal forces is a crucial factor in implant treatment planning. Occlusal forces should be directed along the long axis of the implant. In some areas of the mouth, this is relatively easy to accomplish. In other areas, impossible. With this factor in mind, one can see that at the very beginning of the diagnostic phase, a diagnostic wax up on a set of mounted casts, very well may impart this information, long before the implant is placed.

Angled occlusal forces produce tremendous increases in stress compression as compared to vertical loading. (Kakudo, Y. et al: J. Osaka Univ. Dental School: 6: 126-136; 1972)

It is important to understand that biomechanical risk increases whether an angled load is applied to a perpendicular implant or whether a perpendicular load is applied to an angled implant. As much as possible, reduce angled loads on posterior implant retained single crowns, by keeping occlusal load off of marginal ridges; develop occlusal contact(s), as much as possible along the long axis of the implant.

Osseous tissue resorbs medially and inferiorly (mandible), superiorly (maxilla). The greater the bone loss, the more potential there is for the implant to be placed lingually (palatally) and the more the occlusal stop is placed unrelated to normal anatomy.

The goal of successful occlusal adjustment when delivering crowns on natural teeth and crowns retained by implants in the same treatment plan; or, just delivering crowns retained by implants when natural teeth are present in the quadrant, arch, or mouth, is to drive the natural teeth vertically into their osseous socket (25-56 microns), thus "exposing" the implant to load from the opposing hard tissue stop.

On a light "tap", a single posterior implant retained crown should have a very light contact with the natural teeth adjacent to it having a heavier contact. When the patient closes into maximum intercuspation, with greater force, and/or when the patient squeezes the teeth together tightly; then the occlusal stop on the implant crown should be present but in all cases should be a lighter occlusal stop than on the adjacent teeth. If required,





adjust the occlusion on the implant retained crown to reflect this. The goal is for the implant retained crown to have an occlusal stop along the long axis of the implant, and the natural teeth adjacent to it should bear the load.

Anteriorly, depending on many factors, the dentist may have to have the patient squeeze together tightly in centric as well as lateral protrusive and straight protrusive; given the fact that natural maxillary anterior teeth display movement between 54 & 108 microns even in a healthy dentition.

Implant retained crowns should be checked regularly, as per your normal recall schedule except the key clinical factor in checking implant retained crowns is the occlusion.

Some factors to consider that have not been addressed here are:

1. Is the implant retained crown at the terminal end of the arch?
2. Is the implant retained crown opposing another implant? A non-vital tooth?
3. Anterior Guidance
4. Centric Prematurities
5. Combination treatments including but not limited to :

- a) Multiple single implant crowns with natural teeth and/or crowned teeth co-existing in the same arch or opposing arch.
- b) Splinted implant crowns with natural teeth and or crowned teeth in the same arch or opposing.
- c) Implant retained crowns in conjunction with removable partial dentures; tooth borne or distal extension.
- d) Implant retained crowns opposing a complete denture or opposing a fixed detachable prosthesis.

Dental implant treatments have an excellent success rate. Meticulous handling of the occlusion is of paramount importance in order for these treatments to stand the test of time.

All diagrams are from
Misch, C.E. Dental Implant Prosthetics
Elsevier Mosby; 2005

Jack Lipkin D.M.D.
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Prosthodontists

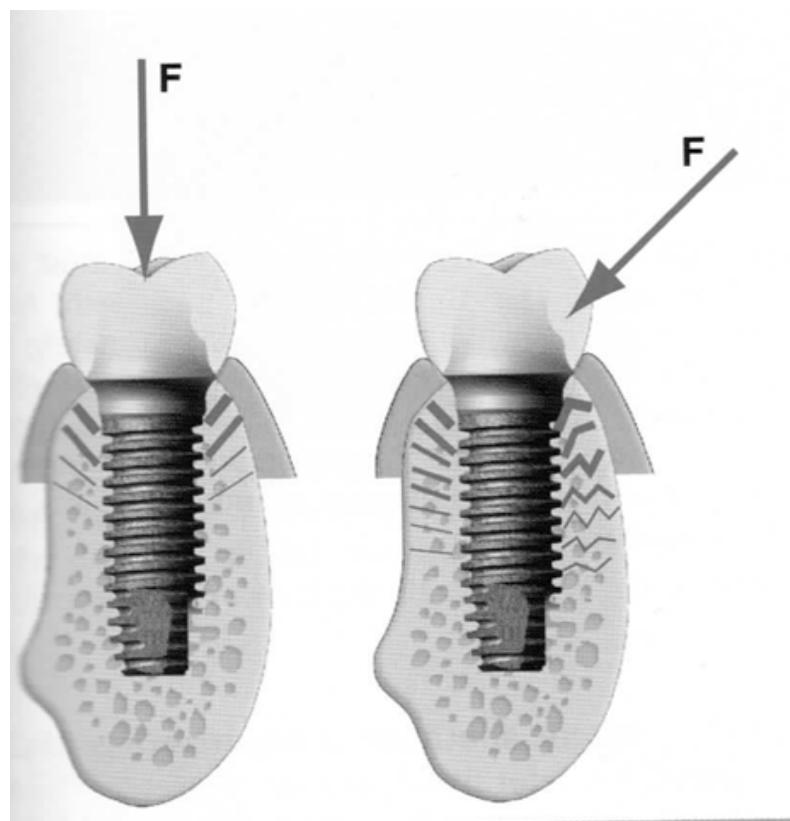


Diagram #1
When an angled load is placed on an implant, tensile and shear forces increase. Bone is weaker to these forces.

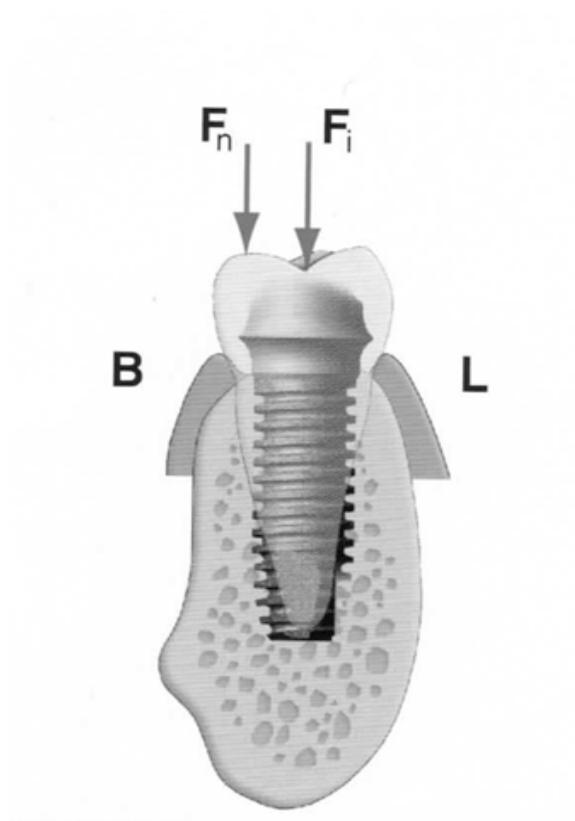


Diagram #2
A buccal cusp contact "Fn", is an offset or cantilever load.



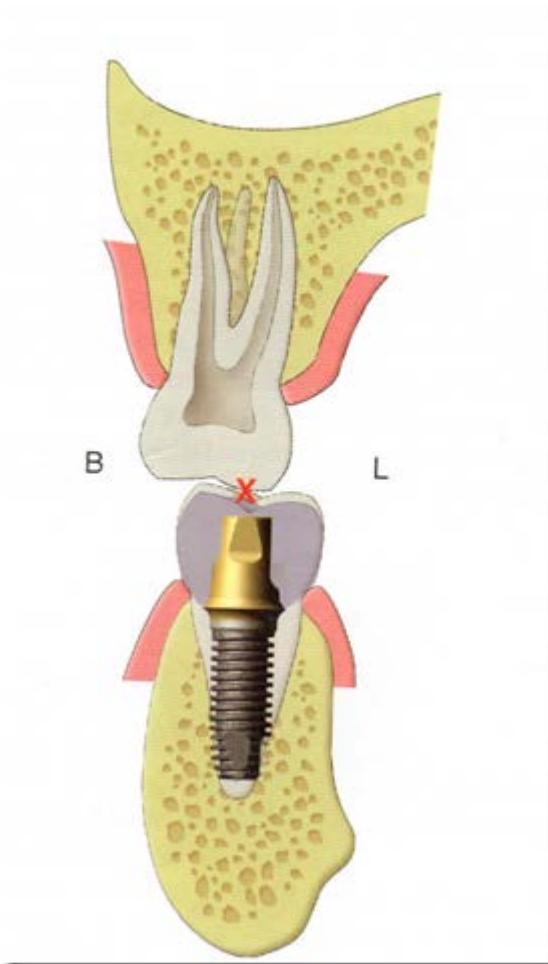


Diagram #3
The primary occlusal contact on an implant should be directed over the long axis of the implant body.

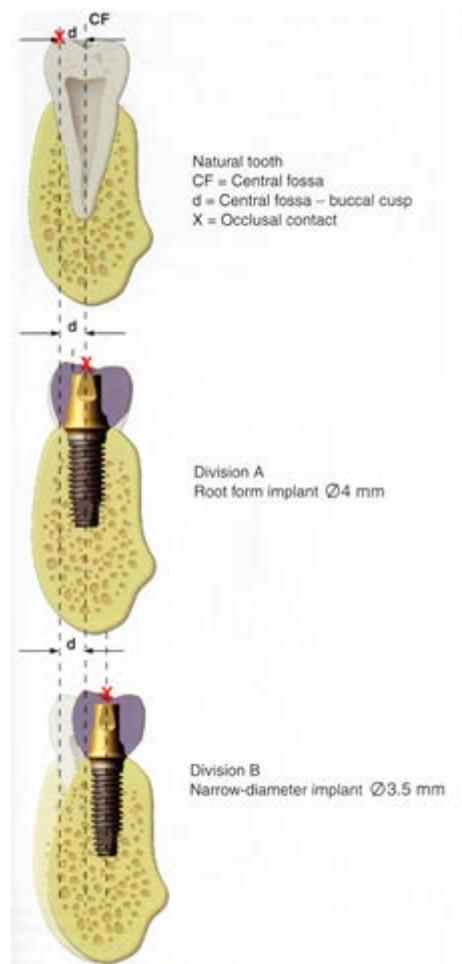


Diagram #4
When bone loss occurs, on the buccal (labial) and bone grafting does not take place (Division B), the implant is placed more lingually, changing the normal anatomy and creating challenges for developing an ideal occlusal scheme.

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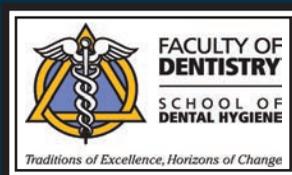
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Faculty Corner



DR. ANTHONY IACOPINO
DEAN OF DENTISTRY
UNIVERSITY OF MANITOBA



EXTREME MAKEOVER

GROWTH AND MATURITY OF FACULTY IDENTITY ACCELERATING AT RAPID PACE

It almost seems hard to imagine but it's been six years since I first touched down here in Manitoba. And as I enter into my second term as Dean of the Faculty of Dentistry, it is amazing to see how far we have come together and what promise the future holds ahead.

Fresh off two of the largest and most significant events of our calendar year – the Pacific Dental Conference in Vancouver and the American Dental Education Association annual meetings – I can honestly say that University of Manitoba alumni are having an impact and making their presence felt like never before.

First off, both events featured record turn-outs at our alumni and academic receptions and, as usual, the events were boisterous and high spirited affairs, filled with alumni and academics from the many different generations of the Faculty's history. Alumni from our very first classes congregated with those of our most recent years to enjoy each other's company in celebration of the common heritage that bonds us all.

This record attendance is a reflection of the alumni presence that is clearly growing along with the recognition that these are important professional events. Our people are getting out and making their presence felt like never before, assuming positions as thought leaders, researchers, innovators and community leaders.

They are doing so proudly under the University of Manitoba banner, and are earning national and international acclaim in the bargain. And it is clearly a mutually beneficial relationship.

As I mentioned in my State-of-the-Faculty address just a short time ago in Vancouver, it's been another great year. We continue to provide a great clinical and technical education while continuing to do things other dental schools in North America simply don't do. We have the most students active in student research, representing our school at international and national meetings in North America, based on our size. We have, and will continue to, make a point of getting to know our students personally and taking an interest in them after graduation. Our Office Visit Series has now made over 350 stops to develop relationships and ensure they are

reconnected with the Faculty. To that end, we have added annual alumni reception gatherings in Calgary and now in Toronto to great effect. As well, each of these events is now fully supported by corporate sponsors as our industry partners see the value in helping us connect with our alumni.

And it is clearly working. At the present time, we have the most part-time alumni ever engaged in the faculty. We have the highest level of financial support ever from our alumni and it just keeps getting better and better. And, as we continue to grow and develop together, I am pleased to share with you another major announcement concerning the future of our Faculty.

Discussions and planning are underway for the University of Manitoba's Bannatyne Campus to undergo a major redevelopment plan; a potential \$350-million initiative that will include the construction of a completely new dental clinic at the Bannatyne Campus.

Such a clinic would be the most unique dental teaching clinic in North America. In the front, the public face of the access clinic will be interprofessional in its focus. We will have physicians, nurses and pharmacists joining with our dentists and Faculty practitioners. The dental teaching clinic will be located as a referral behind that store-front.

This will truly be the practice of the future as we will be working with our health professions colleagues and co-managing patients.

As part of that, the health professions Faculties on Bannatyne Campus are finalizing plans to come together to form one common Faculty of Health Sciences, one that will retain professional college units of dentistry, medicine, nursing and pharmacy.

And we will be doing things together like never before in our approach to interprofessional education, research, and practice that puts dentistry and oral health front and centre in overall healthcare for patients in Manitoba. This concept is broadly supported by government, the healthcare industry and by the university; it is a very exciting future ahead.

Continued on page 17...

Continued from page 16...

I'm in my second term now as dean of the Faculty, and as I mentioned off the top, it's hard to believe I've been here for six years, coming here from the States. And here's the most amazing thing of all: it was – and still is – a great and an exciting time to be Dean of this Faculty.

We continue to grow, mature and progress as never before. Our alumni associations – including our newest group from the School of Dental Hygiene – now boast record membership and are looking to actively engage and help in the development of our Faculty.

Our national and international presence is growing at an equally astonishing rate and our people are in high demand for their skills, thoughts, opinions, expertise and leadership. And now, we appear to be on the cusp of a major upgrade, an extreme makeover if you will, of our teaching and clinical facilities. How completely appropriate, how completely wonderful!

As marvelous and successful as our short history together has been, we are poised on even better times that lie ahead. And it is through your involvement and your participation that all of this was made possible.

The role of Dean of Dentistry at the University of Manitoba is indeed an exciting and worthwhile endeavour. I cherish it every day. I continue to look forward to walking this path with you in the days, weeks, months and years ahead, and I thank all of you for your support and your renewed engagement at the Faculty.

Grazie,

Dr. Anthony M. Iacopino
Dean of Dentistry

MDA DIRECTORY AMENDMENTS

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NOTE: It is important for all dentists and dental assistants to provide written notice of any changes to your mailing address, your licensure status or plans to move to a different province.

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HACKERS, LAWSUITS AND THIEVES...OH MY!

PRACTICAL TIPS TO MITIGATE DENTAL OFFICE LOSSES

Office mishaps can cause major disruptions at your dental practice and create time-consuming headaches for you and your staff. The good news is that if you take the proper steps, many types of office losses can be minimized or even avoided. To give you some insights, consider the following suggestions — based on the real-life cases of dentists who have experienced office losses.

Fraud

A hacker racks up a \$6,000 phone bill on a dentist's line.

During a week-long period, an unknown person was able to hack the telephone system in a dental office. Many phone calls were made to an out-of-country locale via the office phone system, resulting in long-distance charges totaling over \$6,000. Police were notified. The calls were made after office hours and past the time when janitorial staff completed their evening duties, so it was assumed the hacker was able to access the phone system remotely. A password system had not been set up on the phone equipment.

The dentist received a claim payment to cover the cost demanded from the long-distance service provider.

Recommendations: If a hacker attempts to access your phone system and runs into strong safeguards, there is a good chance they will move on to an easier target. Ensure that all manufacturer default passwords for telephone system administration are changed, using lengthy and complex alphanumeric passwords. Ask your telephone service provider about what other security protocols should be implemented.

Slip-and Fall Lawsuit

A dentist's slippery parking lot results in an expensive legal bill.

After a winter-morning appointment, a patient headed towards her car. While in the dental office parking lot, she suffered serious ankle and wrist injuries after slipping on snow and ice. Although the dentist had a verbal agreement with a snow plowing company, he did not have a written contract specifying how often the snow would be removed. The dentist was taken to court and was found responsible for the patient's injuries. His total legal costs amounted to nearly \$18,000.

Recommendations: If you own your practice building, it is your responsibility to have the walkways and steps outside your practice regularly cleared of snow and de-iced. During continuous snowfall or freezing rain, verify that this is being done on an hourly basis and keep a documented schedule. (Keeping this schedule is vital, as it will serve as evidence to support your defence if you're named in a slip-and-fall lawsuit.)

If you have a contract with a snow removal business, ensure the document clearly spells out the responsibilities of each party. The contract should include areas to be cleared, such as walkways, stairways and parking lots. If you lease your office and the landlord is responsible for ensuring that snow is cleared, it's prudent to check if this maintenance is being done.

Consider installing traction mats in your practice hallways and steps and ensure handrails are installed where necessary and are properly secured. Put a procedure in place to ensure any water from melted snow inside your practice is promptly removed.

Theft

Butter-fingered thieves visit a dental office.

Late one evening, a dentist received a call from the practice's alarm-monitoring company. Upon arriving at the office, she saw that the front door window was smashed. Culprits had broken in and ripped down a large flat-screen television from a wall in the reception area, damaging the drywall. Marks were found on the floor nearby, where it appeared the perpetrators had dropped the television. Police found the television outside, damaged beyond repair.

The dentist received an insurance claim payment of approximately \$7,000 to cover the cost of repairing the office and replacing the television.

Recommendations: Close blinds or drapes at night so thieves can't scope the inside of your practice. Darkness hides burglars and makes their work easier, so ensure the exterior of your practice is well-lit. Consider installing metal bars on glass windows and doors.

(Box) Review Your Office Contents Coverage

These claim situations illustrate why it's vital to take preventative measures to protect your office and to have insurance. It's equally important to ensure your insurance coverage is up-to-date. If you have recently renovated your practice or added or upgraded equipment or furnishings in your office, you may need to increase your office contents coverage.

Contact CDSPI's licensed insurance advisors if you have any questions about your office insurance or if you are planning renovations. For a no-cost, no-obligation consultation, call us today at 1-877-293-9455, ext. 5002.

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By Renata Whiteman
Professional Insurance Advisor
CDSPI Advisory Services Inc.
insurance@cdspiadvice.com





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- *Inflammation 911: The Body-Mouth Connection*
- *The ABC's of Tooth Wear - Hypersensitivity and Nutrition*

Dr. Barbara Steinberg - Dentist, Clinical Professor, Hospital Doctor and Women's Health Advocate

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YOUR GUIDE TO BETTER PATIENT COMMUNICATION

Excerpt #5 from the MDA Patient Communication Guide

Making Time To Listen

You are the expert on clinical dentistry, but your patients are the experts on their own decisions and how they impact them. We are expected to express expert opinions based on clinical findings and their implications.



While you will always know more than your patients about dental diseases and problems, you place yourself on precarious ground when you imply that you know better than your patients about how dental care should fit into their lives. When you do so, you cross a boundary; your clinical opinion will have less impact than it might have otherwise.

The road to understanding begins with genuine interest. Curiosity is one of the communication skills you must master if you want to create functional relationships with your patients.

Listening and learning come before telling and educating

In many of our practices, the emphasis is on telling rather than on listening to the patient.

Become interested and curious. Ask. Listen. Ask some more. Listen some more. Understand. Respect. Then, tell. This process puts significant emphasis on understanding our patients before the examination begins.

Counseling techniques are invaluable in gaining an understanding of your patient and helping them adopt new behaviours that are important to promoting good oral health. By first trying to understand your patient's perspective you encourage him or her to develop a sense of competence and autonomy. Rather than telling patients what to do or what is right for them, you can help them find their own way to make needed changes or adopt new behaviours.

Listen effectively

What many of us don't realize is that the most critical and powerful aspects of communication is not speaking, but

listening. Listening shapes speaking. Once we start listening effectively and really understand the thoughts and concerns of our patients, we generate a powerful relationship with them – a relationship that makes a mutual future possible.

Practice listening skills

If your patient feels that you have been an attentive listener he or she will be comforted, reassured, and more likely to leave with a positive impression.

The Power of Apology

If you have erred, say so. Mistakes happen to all of us. Thoughtless comments can be harmful, but taking responsibility can go a long way to regain lost ground.

Defensiveness only escalates situations and makes resolution difficult. Once blame enters the picture, emotions intensify and issues become distorted, making it almost impossible to work through even simple issues.

The implementation of the Apology Act in Manitoba may make professionals feel more comfortable about providing apologies in order to help resolve disputes. Pursuant to the Act, in context, an apology:

- Does not express or imply admission of fault or liability.
- Does not start the time limit for commencing an action under the Limitations Act;
- Does not void, impair or affect insurance coverage that is available; and
- Cannot be taken into account in determining fault or liability.

Communication Skills Checklist

Today's patients expect to play an active role in their oral health care treatment. How can you help encourage their participation and improve your patient relations? The answer is simple: Learn to be an effective communicator even if you are busy, you simply need to communicate 'smarter' to make better use of the time you have.

Communication with your patient is an art. The best communicators have an open mind, receptive ear and an empathetic heart. Their skills are perfected through practice, experience and feedback from patients, staff and colleagues.

You can work on improving your interpersonal skills by following these tips:

Listen: The first and foremost component of providing excellent patient care is to listen — Let patients talk so you can adequately take in and understand what they are saying. While your tendency may be to ask your patients a lot of questions upfront, you'll get more information and save time in the long run by actively listening to your patient without interrupting. Ask only relevant questions: Get to the underlying issue so you can quickly get to a resolution, or at a minimum a plan of action to get to a resolution.

Be polite: Kindness and politeness are like sugar, sweetening even the worst situations. When a patient is anxious, angry or concerned they are looking to you to help them. Responding negatively, harshly or without concern will only worsen the situation and very likely cost you a patient.

Remember your manners: Patients are more likely to follow your advice if they have a good relationship with you. How you conduct yourself is very important. Walk in with a smile, shake the patient's hand, call the patient by name and sit down. You can also help to put your patient at ease by starting off with a simple "How can I help you".

Don't appear rushed, even if you are: Patients get irritated when their dentist appears hurried. Make each patient feel that they are the sole focus of your attention. Sitting down and talking is far more effective than talking while standing up.

Dealing with difficult patients

Learn to see each problem as an opportunity for improvement. Here are some steps in dealing with difficult patients:

1. Avoid downplaying the seriousness of the patient's complaint. Let the patient tell you their side of the story without interruption. Sometimes all they need is to be heard.

2. Express empathy. Let the patients know that you understand the problem and are concerned about their feelings.

3. Patients need to hear that you are on their side and are willing to do whatever it takes to solve their problem.

4. Do not go on the defensive. You are certain to lose the patient if you become confrontational.

5. Take control of the situation. Once you have heard the patient's side of the story, take the appropriate action to resolve the problem.

6. Ask the patient what they want. You may be surprised to find that the patient's solution to the problem is both fair and simple.

7. Once you have established a written plan of action, explain to your patient how the plan will solve the problem.

8. Ensure that the plan has been carried out and the results are acceptable to your patient — follow-up to ensure your patient is happy with the way you have handled the problem.

By following these simple steps your most difficult patient can become your most valuable patient.

Experience shows that a dissatisfied patient will share their story with more people than will a satisfied patient.



Guys AND DOLLS

The All-Dentist Musical

Dentists Participating as Musical Cast Members:



Dr. Cheryl Bacala
(Agatha/Ferguson, Dancer)



Dr. Tom Colina
(Nicely-Nicely Johnson)



Dr. Chris Cottick
(Joey Biltmore/MC/The Greek)



Dr. Katie Davidson
(Sarah Brown)



Dr. Tom Dobbs
(Arvide Abernathy/
Scranton Slim)



Dr. Cecilia Dong
(Allison, Dancer)



Dr. Khalida Hai-Santiago
(General Matilda B.
Cartwright)



Dr. Ken Hamin
(Nathan Detroit)



Dr. Frank Hechter
(Big Jule)



Dr. Hoda Hosseini
(Mimi, Dancer)



Dr. Billy Kettner
(Harry The Horse)



Dr. Tricia Magsino-Barnabe
(Miss Adelaide)



Dr. Wally Mah
(Benny Southstreet)



Dr. Rob Malech (Calvin/Brandy
Bottle Bates/Waiter)



Dr. Sandy Mutchmor
(Lt. Brannigan/Crapshooter)



Dr. Sam Paulos
(Sky Masterson)



Dr. George Stolarsky
(Rusty Charlie)



Dr. Kristen Cuthbert
(Vernon, Dancer)

Dentists on the Musical Project Volunteer Committee:

Dr. Suzanne Carriere • Dr. Charles Lekic • Dr. Phong Luong • Dr. Tricia Magsino-Barnabe (Chair) • Dr. Susan Tsang • Dr. Ben Yue • Dr. Chris Yue

Special thanks to:

Dr. Tim Dumore (Promotions) • Dr. Natalia Ksiazkiewicz (Dance Assistant)

Performances:

Thursday, May 9th - 8pm (rush seating) Tickets: \$40 • Friday, May 10th - 8pm (Gala night) Tickets: \$65 • Saturday, May 11th - 8pm Tickets: \$50 • Sunday, May 12th - 2pm Tickets: \$50

Can't come to the show? You can still lend your support!

Donations to CancerCare Manitoba Foundation: www.cancercarefdn.mb.ca

For Guys and Dolls sponsorship/advertising/donation information contact Haanita Seval at marketdev@pte.mb.ca

PLUS! Enter to win a Hearts on Fire diamond pendant (\$2,690 value) from Independent Jewellers! Tickets are \$10 each - only 500 are available!
Contact Bruce Michalski, PTE Publicity Co-ordinator at 204-925-5269.

Tickets: Call 204.942.5483 Online: www.pte.mb.ca

All proceeds to support Prairie Theatre Exchange and CancerCare Manitoba for Head and Neck Cancer patients.
Please consider a gift to Head and Neck Cancer patients through the CancerCare Manitoba Foundation. For more information, please call 204-787-4143 or visit www.cancercarefdn.mb.ca.